2015

SUMMARY OF BENEFITS

CITY OF SPRINGFIELD

Coventry Advantage (HMO)

Offered by
Coventry Health Care of Missouri, Inc.

SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

YOU HAVE CHOICES ABOUT HOW TO GET YOUR MEDICARE BENEFITS

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **Coventry Advantage (HMO)**).
- You may have other options too, such as a Medicare group plan offered through your employer group, union or trust.

TIPS FOR COMPARING YOUR MEDICARE CHOICES

This Summary of Benefits booklet gives you a summary of what **Coventry Advantage (HMO)** covers and what you pay.

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on http://www.medicare.gov.

- If you want to know more about the coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at http://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTIONS IN THIS BOOKLET

- Things to Know About **Coventry Advantage (HMO)**
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Prescription Drug Benefits
- Covered Medical and Hospital Benefits

This document is available in other formats such as Braille and large print.

This document may be available in a non-English language. For additional information, call us at 1-(800)-727-9712.

Things to Know About **Coventry Advantage (HMO)**

Hours of Operation

- From October 1 to February 14, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Central time.
- From February 15 to September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. Central time.

Coventry Advantage (HMO) Phone Numbers and Website

- If you are a member of this plan, call toll-free 1-(800)-727-9712.
- If you are not a member of this plan, call toll-free 1-(800)-727-9712.
- Our website: http://www.coventry-medicare.coventryhealthcare.com

WHO CAN JOIN?

To join **Coventry Advantage (HMO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Our service area includes the following counties in
Arkansas: Benton, Carroll, Crawford, Franklin, Logan, Montgomery, Scott, Sebastian, Washington.

Kansas: Butler, Harvey, Johnson, Miami, Sedgwick, Wyandotte

Missouri: Barry, Bates, Cass, Cedar, Christian, Clay, Dade, Dallas, Douglas, Greene, Hickory, Jackson, Laclede, Lawrence, Phelps, Platte, Polk, Pulaski, Stone, Taney, Webster, Wright

Oklahoma: Canadian, Oklahoma.

WHICH DOCTORS, HOSPITALS, AND PHARMACIES CAN I USE?

Coventry Advantage (HMO) has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these pharmacies.

You can see our plan's provider and pharmacy directory at our website (http://www.providerdirectory.coventry-medicare.com).
Or, call us and we will send you a copy of the provider and pharmacy directories.

WHAT DO WE COVER?

Like all Medicare health plans, we cover everything that Original Medicare covers - and *more*.

- **Our plan members get *all* of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare.** For others, you may pay less.
- **Our plan members also get *more than what is* covered by Original Medicare.** Some of the extra benefits are outlined in this booklet.

We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, http://KSformulary.coventry-medicare.com.

Or, call us and we will send you a copy of the formulary.

HOW WILL I DETERMINE MY DRUG COSTS?

Our plan groups each medication into one of five "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Initial Coverage, Coverage Gap, and Catastrophic Coverage.

If you have any questions about this plan's benefits or costs, please contact COVENTRY HEALTH CARE for details.

SECTION II - SUMMARY OF BENEFITS	
Coventry Advantage (HMO)	
MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES	
How much is the monthly premium?	**$193.00** per month. In addition, you must keep paying your Medicare Part B premium.
How much is the deductible?	This plan does not have a deductible.
Is there any limit on how much I will pay for my covered services?	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. In this plan, you will pay nothing for Medicare-covered services from in-network providers. Your yearly limit(s) in this plan: $6,700 for services you receive from in-network providers If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.
Is there a limit on how much the plan will pay?	Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.
COVERED MEDICAL AND HOSPITAL BENEFITS	
NOTE: **SERVICES WITH A [1] MAY REQUIRE PRIOR AUTHORIZATION.** **SERVICES WITH A [2] MAY REQUIRE A REFERRAL FROM YOUR DOCTOR.**	

OUTPATIENT CARE AND SERVICES	
Acupuncture and Other Alternative Therapies	Not covered
Ambulance[1]	$50 copay Non-emergent transportation requires prior authorization. Cost sharing is listed for a one-way trip.
Chiropractic Care	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): $20 copay
Dental Services	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): $20-100 copay, depending on the service: • Medicare covered dental office services: $20 copay • Medicare covered dental services at an outpatient hospital facility or ambulatory surgical facility: $100 copay If a doctor provides services in addition to your exam, separate physician or facility cost sharing may apply.
Diabetes Supplies and Services[1]	Diabetes monitoring supplies: $0-5 copay or 20% of the total cost • Glucose monitors from our preferred vendor One Touch/Lifescan: You pay nothing. • Diabetic test strips and lancets from our preferred vendor One Touch/Lifescan: You pay nothing. • Glucose monitors from non-preferred Vendors (non-One Touch/Lifescan) 20% of the total cost. • Diabetic test strips and lancets from non-preferred vendors (non-One Touch/Lifescan): $5 copay. Diabetes self-management training: You pay nothing Therapeutic shoes or inserts: 20% of the total cost If a doctor provides services in addition Diabetes self-

	management training, separate physician or facility cost sharing may apply. (*See Doctor's office visits)* Diabetic supplies and services are limited to specific products and/or brands. Prior authorization is required for non-Lifescan monitors and testing supplies, test strips (any brand) in excess of 100 strips every 30 days, and monitors (any brand) in excess of one monitor per year.
Diagnostic Tests, Lab and Radiology Services, and X-Rays[1]	• Diagnostic radiology services (such as MRIs, CT scans): You pay nothing • Diagnostic tests and procedures: You pay nothing • Lab services: You pay nothing • Outpatient x-rays: You pay nothing • Therapeutic radiology services (such as radiation treatment for cancer): You pay nothing If a doctor provides services in addition to diagnostic tests and therapeutic services, separate physician or facility cost share may apply. *(See Doctor's office visit or Outpatient Surgery/Outpatient hospital)*
Doctor's Office Visits	Primary care physician visit: $15 copay Specialist visit: $20 copay A separate cost share may apply to certain diagnostic tests. *(See Diagnostic Tests, Lab and Radiology Services, and X-ray)*
Durable Medical Equipment *(Wheelchairs, oxygen, etc.)*[1]	20% of the total cost
Emergency Care	$50 copay If you are admitted to the hospital within 24 hours, you do not have to pay your share of the total cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs. We provide worldwide coverage for emergency care.
Foot Care *(podiatry services)*	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: $20 copay Routine visit (up to 6 per year): $20 copay
Hearing Services	Exam to diagnose and treat hearing and balance issues: $20 copay Routine hearing test (up to 1 per year): $20 copay

Home Health Care[1]	You pay nothing If home health services do not require authorization. If home health agency provides services in addition to skilled nursing or therapy, separate cost sharing or authorization requirement may apply.
Mental Health Care[1]	Inpatient visit: Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. Our plan covers 90 days for an inpatient hospital stay. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. $50 copay per day for days 1 through 5 You pay nothing per day for days 6 through 90 You pay nothing for lifetime reserve days Outpatient group therapy visit: $10 copay Outpatient individual therapy visit: $20 copay Partial hospitalization: $20 copay
Outpatient Rehabilitation[1]	Pulmonary and Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): You pay nothing Occupational therapy visit: You pay nothing Physical therapy and speech and language therapy visit: You pay nothing
Outpatient Substance Abuse[1]	Group therapy visit: $10 copay Individual therapy visit: $20 copay
Outpatient Surgery[1]	Ambulatory surgical center: $100 copay Outpatient hospital: $100 copay A separate cost share may apply to certain diagnostic tests. (*See Diagnostic Tests, Lab and Radiology Services, and X-ray)*

Over-the-Counter Items	Not Covered
Prosthetic Devices *(braces, artificial limbs, etc.)*[1]	Prosthetic devices: 20% of the total cost Related medical supplies: 20% of the total cost
Renal Dialysis[1]	You pay nothing
Transportation	Not covered
Urgent Care	$25 copay
Vision Services	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $0-20 copay, depending on the service: • Medicare-covered exams to diagnose and treat disease and conditions of the eye: $20 copay • Glaucoma screening: You pay nothing • Routine eye exam (for up to 1 every year): $20 copay Eyeglasses or contact lenses after cataract surgery: In-network: You pay nothing Eyeglasses frames: In-network: You pay nothing Eyeglasses lenses: In-network: You pay nothing Our plan pays up to $150 every two years for eyeglasses (frames and lenses), eyeglass lenses and eye glass frames from any provider. If a doctor provides services in addition to your exam, separate physician or facility cost sharing may apply.
Preventive Care	You pay nothing Our plan covers many preventive services, including: Abdominal aortic aneurysm screening Alcohol misuse counseling Bone mass measurement Breast cancer screening (mammogram)

	Cardiovascular disease (behavioral therapy) Cardiovascular screenings Cervical and vaginal cancer screening Colonoscopy Colorectal cancer screenings Depression screening Diabetes screenings Fecal occult blood test Flexible sigmoidoscopy HIV screening Medical nutrition therapy services Obesity screening and counseling Prostate cancer screenings (PSA) Sexually transmitted infections screening and counseling Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots "Welcome to Medicare" preventive visit (one-time) Yearly "Wellness" visit Any additional preventive services approved by Medicare during the contract year will be covered. Wellness education and supplemental benefits and services include: Health Education with semi-annual newsletters Nutritional Benefits which are available by a licensed nutritionist or other healthcare provider as part of Disease Management. Nursing Hotline to call a nurse for assistance with Medical questions 24-hours a day, 7-days a week. Membership in Health Club/Fitness Classes through a network of participating fitness facilities. Goal is to promote fitness, exercise and better health choices and improve the overall health of participating members. Members will receive an orientation to the gym facility and its equipment. You pay nothing.
Hospice	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the total cost for drugs and respite care.
INPATIENT CARE	

Inpatient Hospital Care[1]	Our plan covers an unlimited number of days for an inpatient hospital stay. $50 copay per day for days 1 through 5 You pay nothing per day for days 6 through 90 You pay nothing per day for additional non-Medicare covered hospital days Your inpatient benefits will begin on day one each time you are admitted within or to a specific facility type. A transfer within or to a facility, including Inpatient Rehabilitation, Long Term Acute Care, Inpatient Acute or Psychiatric facility is considered a new admission.
Inpatient Mental Health Care	For inpatient mental health care, see the "Mental Health Care" section of this booklet.
Skilled Nursing Facility (SNF)[1]	Our plan covers up to 100 days in a SNF. You pay nothing per day for days 1 through 20 $156.50 copay per day for days 21 through 100

PRESCRIPTION DRUG BENEFITS

How much do I pay?

For Part B drugs such as chemotherapy drugs[1]: 0% of the total cost
Other Part B drugs[1]: 0% of the total cost.

Some immunizations are covered under your Prescription Drug plan and can be administered by your pharmacist. Your cost share may be higher if you get these immunizations at your doctor's office.

Initial Coverage

You pay the following until your total yearly drug costs reach $2,960. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies.

Preferred Retail Cost-Sharing			
Tier	**One-month supply**	**Two-month supply**	**Three-month supply**
Tier 1 (Preferred Generic)	$0	$0	$0
Tier 2 (Non-Preferred Generic)	$5 copay	$10 copay	$10 copay
Tier 3 (Preferred Brand)	$45 copay	$90 copay	$90 copay
Tier 4 (Non-Preferred Brand)	50% of the total cost	50% of the total cost	50% of the total cost
Tier 5 (Specialty Tier)	33% of the total cost	Not Offered	Not Offered
Standard Retail Cost-Sharing			
Tier	**One-month supply**	**Two-month supply**	**Three-month supply**
Tier 1 (Preferred Generic)	$0	$0	$0
Tier 2 (Non-Preferred Generic)	$5 copay	$10 copay	$10 copay
Tier 3 (Preferred Brand)	$45 copay	$90 copay	$90 copay
Tier 4 (Non-Preferred Brand)	50% of the total cost	50% of the total cost	50% of the total cost
Tier 5 (Specialty Tier)	33% of the total cost	Not Offered	Not Offered
Standard Mail Order Cost-Sharing			
Tier	**One-month supply**	**Two-month supply**	**Three-month supply**
Tier 1 (Preferred Generic)	$0	$0	$0
Tier 2 (Non-Preferred Generic)	$5 copay	$10 copay	$10 copay
Tier 3 (Preferred Brand)	$45 copay	$90 copay	$90 copay
Tier 4 (Non-Preferred Brand)	50% of the total cost	50% of the total cost	50% of the total cost
Tier 5 (Specialty Tier)	33% of the total cost	Not Offered	Not Offered

If you reside in a long-term care facility, you pay the same as at a retail pharmacy.

You may get drugs from an out-of-network pharmacy and pay the same as an in-network pharmacy, but you will get less of the drug.

Coverage Gap

Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $2,960.

After you enter the coverage gap, you pay 45% of the plan's cost for covered brand name drugs and 65% of the plan's cost for covered generic drugs until your costs total $4,700, which is the end of the coverage gap. Not everyone will enter the coverage gap.

Under this plan, you may pay even less for the brand and generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug's tier. See the chart that follows to find out how much it will cost you.

Preferred Retail Cost Sharing

Tier	Drugs Covered	One-month supply	Two-month supply	Three-month supply
Tier 1 (Preferred Generic)	All	$0	$0	$0
Tier 2 (Non-Preferred Generic)	All	$5 copay	$10 copay	$10 copay
Tier 3 (Preferred Brand)	All	$45 copay	$90 copay	$90 copay
Tier 4 (Non-Preferred Brand)	All	50% of the total cost	50% of the total cost	50% of the total cost
Tier 5 (Specialty Tier)	All	33% of the total cost	Not offered	Not offered

Standard Retail Cost Sharing

Tier	Drugs Covered	One-month supply	Two-month supply	Three-month supply
Tier 1 (Preferred Generic)	All	$0	$0	$0
Tier 2 (Non-Preferred Generic)	All	$5 copay	$10 copay	$10 copay
Tier 3 (Preferred Brand)	All	$45 copay	$90 copay	$90 copay
Tier 4 (Non-Preferred Brand)	All	50% of the total cost	50% of the total cost	50% of the total cost
Tier 5 (Specialty Tier)	All	33% of the total cost	Not offered	Not offered

Standard Mail Order Cost Sharing

Tier	Drugs Covered	One-month supply	Two-month supply	Three-month supply
Tier 1 (Preferred Generic)	All	$0	$0	$0
Tier 2 (Non-Preferred Generic)	All	$5 copay	$10 copay	$10 copay
Tier 3 (Preferred Brand)	All	$45 copay	$90 copay	$90 copay
Tier 4 (Non-Preferred Brand)	All	50% of the total cost	50% of the total cost	50% of the total cost
Tier 5 (Specialty Tier)	All	33% of the total cost	Not offered	Not offered

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $4,700, you pay the greater of:

5% of the total cost or $2.65 copay for generic (including brand drugs treated as generic) and a $6.60 copayment for all other drugs.